

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

HEPATITIS A INVESTIGATION FORM

OTSG APPROVED (Date)

1. Reason for referral		2. Age	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	4. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single
		5. Place of birth		
6. Status <input type="checkbox"/> Active duty <input type="checkbox"/> Retiree <input type="checkbox"/> Dependent <input type="checkbox"/> Other:		7. Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian		
8. Race <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Malaise and pain <input type="checkbox"/> Tenderness <input type="checkbox"/> Jaundice <input type="checkbox"/> Fever <input type="checkbox"/> Anorexia				
9. Date of onset of symptoms	10. Lost time from work or school	11. Lab tests		
		a. Date:	b. IgM:	c. IgG:
12. Recent travel history				
13. Eating history				
	12 hours prior to onset of symptoms	24 hours prior to onset of symptoms	48 hours prior to onset of symptoms	
Where ate:				
What ate:				
Note: Raw fish and shellfish are high risk foods.				
14. Has the patient had contact with another person who had hepatitis A or symptoms of hepatitis A? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain:				
15. Has the patient had contact with urine or stool? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," explain:				
16. List household contacts				
Name	Age	Symptoms		

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)		<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT